

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-011170

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

F

Registration District No.

128

Primary Registration District No.

2000

Registrar's No.

440

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH

a. COUNTY

Greene

b. CITY (If outside corporate limits, give TOWNSHIP only)

Springfield

Length of stay in 1b

22 days

c. FULL NAME OF (If NOT in hospital, give location)

Burge Protestant Hosp.

Inside Limits

Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

Greene

c. CITY

OR

TOWN

Springfield

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

1016 E. Talmadge

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

LEONARD

Middle

MARION

Last

BILLINGS

4. DATE OF DEATH

Month

Day

Year

March 21, 1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8 Jul 01

9. AGE (last birthday)

61

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Rod Carrier

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (City and state or country)

Table Rock, Neb.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Thomas Billings

13b. MOTHER'S MAIDEN NAME

Arnoldy

14. NAME OF HUSBAND OR WIFE

Edith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Edith Billings - As in 2d

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma Lung Rt Upper Lobe
± cerebral metastases

INTERVAL BETWEEN ONSET AND DEATH

6 wks.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 2-10-63 to 3-21-63 and last saw her alive on 3-21-63

Death occurred at 10:12 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

3-24-63

23c. NAME OF CEMETERY OR CREMATOR

Sparta Cemetery

23d. LOCATION (City, town, or county)

Sparta, Missouri

(State)

24. FUNERAL DIRECTOR

ADDRESS

Wm. K. Ferrell, Rogersville, Mo.

25. DATE RECD. BY LOCAL REG.

3-26-63

26. REGISTRAR'S SIGNATURE

Effie S. Melton

(Licensed Embalmer's Statement on Reverse Side)

APR 3 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Mr. K. Ferrell

Licensed Embalmer No. 4910

P. O. Address Rogersville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.